



Annual Physical/Wellness Visit Affidavit Form



Instructions for Physician

Complete and sign Section 2 of this form to verify physical exam/wellness visit
Return form to the patient for submission or submit the form no
later than 8/31/2026 to:

Innovative Workplace Wellness
Fax to (888) 739-1722 or
Scan and E-mail to wellness@ibpllc.com

Section #1 -Employee/Spouse Completes

Form with fields: Name (Last, First), DOB (mm/dd/yyyy), Gender (Male/Female), Relationship to Policy Holder (Self/Spouse/Dependent), Employee ID #, Address (Street, City, State, Zip), Email, Best Phone #, Employer Name (Oaks Integrated Care), Primary Healthcare Provider Name, Primary Healthcare Provider Phone #.

Would you like verification of receipt of this form sent to the above email? Yes No

Authorization to Release Protected Health Information to my Employer

I understand that by submitting this form, Innovative Workplace Wellness will be reporting to my employer
the following information to apply the incentive to my health premium: Name, Payroll Deduction, and if I
have verified that I have received my annual physical and labs by submitting this form. No other personal
information will be shared.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Section #2 - Healthcare Provider Completes

Date of Annual Physical/ Wellness Visit: \_\_\_\_\_

By signing below, you are authorizing that the employee named above completed an annual wellness exam in
which the most recent laboratory results were discussed along with other preventative screenings deemed
appropriate. With this documentation, the employee/spouse will be eligible for healthcare incentives through
the employer, Oaks Integrated Care.

Primary Healthcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Healthcare Provider NPI #: \_\_\_\_\_

If you have any questions regarding your benefits or wellness program options, contact Innovative Workplace Wellness at
wellness@ibpllc.com or call toll free 888-427-7383.